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EDITORIAL

SHOULD THE CAPABILITY APPROACH BE APPLIED IN HEALTH ECONOMICS?

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SUMMARY

This editorial questions the implications of the capability approach for health economics. Two specific issues are considered: the evaluative space of capablities (as opposed to health or utility) and the decision-making principle of maximisation. The paper argues that the capability approach can provide a richer evaluative space enabling improved evaluation of many interventions. It also argues that more thought is needed about the decision-making principles both within the capability approach and within health economics more generally. Specifically, researchers should analyse equity-oriented principles such as equalisation and a 'decent minimum' of capability, rather than presuming that the goal must be the maximisation of capability. Copyright © 2008 John Wiley & Sons, Ltd.

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What theoretical underpinning should the normative assessment of health-care interventions have? This question continues to exercise health economists. Although the non-welfarist (extra-welfarist, Culyer, 1989) and decision maker (Sugden and Williams, 1978) approaches with health as the main unit of outcome are arguably foremost, there are challenges. These come from welfarist approaches using both willingness to pay and the assessment of experienced utility (Dolan and White, 2006) and from new approaches based on empirical ethics (Richardson and McKie, 2005) and capability (Sen, 1993).

The capability approach is perhaps the most recent to be explored in relation to health economics (Cookson, 2005). Developed by Amartya Sen, the capability approach advocates the evaluation of programmes on the basis of the extent to which a person is *able* (has the capability) to function in a particular way, whether or not he or she chooses to do so (Sen, 1993). Sen illustrates the difference between capability and functioning with the example of two people, one of whom is starving and the other of whom chooses to fast. Both have similar functioning, but the first does not have capability whereas the second does (although they choose not to exercise it) (Sen, 1993). The evaluation of capability may be both in terms of well-being and what Sen refers to as 'agency goals', where the latter may include goals other than one's own well-being. Sen's theory does not, however, impose any particular capabilities for evaluation, and instead the approach is seen as being a broad framework for evaluating policy (Robeyns, 2006) that can provide an alternative to welfare economics—as Sen states 'It differs from the standard utility-based approaches in not insisting that we must value only

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happiness (and sees, instead, the state of being happy as one among several objects of value)…' (Sen, 1993).

The use of the capability approach has potentially very different implications for health economics compared with either welfarist or current non-welfarist approaches focusing on health. Foremost is the difference in evaluative space. Although Culyer drew on the different (from welfarism) evaluative space offered by the capability approach in his exposition of extra-welfarism in the late 1980s, he limited the focus both to one dimension (health) and to functioning rather than capability (i.e. health status rather than the freedom (capability) to pursue health improvement) (Culyer, 1989). The capability approach offers a potentially much richer set of dimensions for evaluation. Although Sen has avoided providing a single list of capabilities, others in the field have generated such lists, notably Nussbaum's ten 'Central Human Capabilities' that provides a 'universal' set of capabilities comprising life, bodily health, bodily integrity, senses, imagination and thought, emotions, practical reason, affiliation, other species, play, and control over one's environment (Nussbaum, 2003). Economists could potentially work with such lists of capability (for example, current work utilising a questionnaire developed by Anand and van Hees (2006) drawing on Nussbaum's list (Lorimer *et al*., 2007)) or alternatively develop new lists focusing on particular population groups and what they want to achieve in their lives (for example, current work developing and valuing a set of attributes for older people in the UK (Grewal *et al*., 2006) and current work looking at capabilities important to those experiencing chronic pain (Kinghorn *et al*., 2007)).

The nature of the evaluation conducted within this evaluative space is also, however, perceived very differently in the capabilities literature. The capability approach avoids the use of individuals' own preferences in evaluation. The grounds for this are largely related to adaptation; individuals may not recognise their own lack of capability because they have adapted to their situation. The approach has a number of implications. First, the accepted method for developing lists of capabilities is on the basis of philosophy and individual researcher's views followed by the public defence of these lists (Robeyns, 2003) rather than qualitative and survey research into patient and public subjective perceptions of health. Second, a desire for some 'objective' measure of capability means that there has been little focus on generating questionnaires to measure people's capabilities, because such questionnaires are seen as providing information about perceived rather than actual capabilities. The issue of how to generate a capability (rather than a functioning) in such questionnaires is therefore only starting to be tackled. One option is to preface questions about functionings with terms such as 'can' and 'are able to'. Another is to assess factors that can be directly related to capabilities, for example, literacy, as in the Human Development Index (Anand and Sen, 1994). This area of work, however, requires further research. Third, personal preferences are not seen by Sen as being definitive for the generation of weights or values to be given to different capabilities, leaving questions about how information about these weights/values should be generated and whose views should be incorporated (Cookson, 2005).

The capabilities literature takes a more expert-centred approach than that of the health and health economics literatures where patients' and public views are increasingly given prominence over those of experts and professionals. In health care, expert-centred methods are unlikely to be tenable given the cultural shifts towards patient and public involvement in health-care decision making. There are, therefore, choices for those who favour the capability approach about the extent to which they operationalise the approach in its 'pure' form and the extent to which they adapt it for use in the health-care environment.

These are not the only questions to face researchers, however. There are other aspects of the capability approach that could have fundamental implications for health economics. In contrast to all current health economics approaches, which have retained a maximisation principle, the capability approach also changes the focus of evaluation. In particular, where non-welfarism retains the decision-making principle of maximisation, the capability approach has *primarily* been concerned with equity, the equality of basic capabilities (Sen, 1982). This leaves economists who are interested in applying the

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capability approach with a dilemma. Does the capability approach make sense within a maximisation framework, that is, aiming to maximise the overall level of capability within a society?

Maximisation within welfarism is conducted on the basis that individuals are the best judges of their own welfare, that an improvement in one person's welfare without a loss in any other person's welfare can be seen as an improvement in social welfare, and that a movement to a particular state can also be perceived as beneficial if those gaining from the move could potentially compensate those who lose. The extra-welfarist and decision maker approaches have retained the mathematically tractable maximisation basis, on the assumption (despite evidence to the contrary) that maximisation of health is the sole or main aim of society in relation to health.

The application of maximisation to a broader capability approach would generate some concerns. The use of a welfarist theoretical basis would be somewhat questionable on the following reasoning. While in an economy, obtaining the highest level of output makes sense because it can then be distributed around that economy fairly, in relation to capability (or indeed health) this makes little sense because it is not possible to transfer capability from one individual to another. Essentially, production and distribution are separable for money (or for utility obtained from the acquisition of goods and services), but not for capability. There is little evidence from society that maximising capability without a concern for the distribution of that capability would be an acceptably policy approach.

The alternative might be for health economists to consider alternative bases for thinking about the allocation of resources within health care. Getting the best allocation of resources from the health-care system might mean, for example, providing a decent minimum level of capability for as many people in society as possible (essentially considering the production and distribution of health in combination rather than separately), rather than maximising the total level of capability regardless of distribution.

Hence, given these issues, should the capability approach be applied in health economics? We would advance a (cautious) 'yes' for two reasons. First, it potentially provides a richer evaluative space enabling better evaluation of many interventions such as those within public health, health promotion and social marketing. It should not be applied blindly, however, because there are aspects of the theory and its current application that will not be supported in the health world and that will require adaptation for use in a health economics context. Second, and perhaps more important, the capability approach may force health economists to reflect more carefully about ethical intricacies, theoretical and empirical inconsistencies and the implications of value judgements that are taken for granted, and ultimately help to develop a more coherent health economics discipline, more firmly grounded in societies' values.

CONFLICT OF INTEREST

None of the authors have conflicts of interest of the type described below in relation to this paper.

- Direct financial payment to an author for the research or manuscript production by the sponsor of a product or service evaluated in an article.
- Ownership of shares by an author in the company sponsoring a product or service evaluated in an article (or in a company sponsoring a competing product).
- Personal consultancies with companies or other organisations with a financial interest in the promotion of particular health-care products and services.

ETHICS

This manuscript does not report empirical data and so no ethics committee approval was required.

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